HEALTH SERVICES and JUVENILE DELINQUENCY

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A report on a conference on the role of health services in preventing dissocial behavior

U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Social Security Administration
Children's Bureau

INTRODUCTION

For the past three years the Children's Bureau, aided by the privately financed Special Juvenile Delinquency Project, has conducted a vigorous program to aid States and local communities in their endeavors to prevent and treat juvenile delinquency. As a part of that program a series of conferences was held, bringing together persons concerned with various facets of the problem of delinquency in order that ways and means of doing a better preventive and treatment job might be explored. This report is based on the deliberations of a conference called for the purpose of determining how and in what ways health services could contribute to the prevention and treatment of dissocial behavior. The conference met for a three-day session, beginning May 19, 1955, in Washington, D. C. Special grants from the Milbank Memorial Fund and the United Automobile Workers-CIO to the Juvenile Delinquency Project made it possible for the Project to cooperate with the Bureau in planning and conducting the conference.*

For the purposes of planning and conducting the conference health was defined as "that state of being in which a person is adjusted to his environment and functions at full potential capacity." Disease was defined as "all forms of physical and emotional maladjustment that impair function." The inclusive term "health services" was used in the conference to embrace all medically oriented professional services concerned with the development and maintenance of health and with the diagnosis and treatment of disease.

The conference was concerned with the role of health personnel in the prevention and treatment of dissocial behavior. The term "health personnel" was defined as "all persons who offer health service whether by private or public means." The conference, therefore, considered the work of the physician in private practice, whether general or specialized; the work of the staff of public health departments; school health workers, public health nurses; medical social workers; nutritionists; and kindred individuals. The conference did not consider the contribution of mental health specialists, but rather the mental health contribution of other health personnel who do not have extensive specialized training in mental health. Nor did the conference consider the contribution that is made by welfare workers. This did not, of course, reflect a lack of appreciation of the contributions of such professional persons as the psychiatrist, the psychologist, and the case workers in the program to combat delinquency. Rather, it reflected a practical recognition of the fact that these professions already have a fairly well defined function

*See Appendix 1 for list of conference participants

in the delinquency control program. The new frontier to be explored was the job of the health worker who does not specialize in mental health, but who can make a significant contribution to its preservation and in particular to the healthy development of the personalities of children.

The importance of the contribution which health personnel can make to the prevention of dissocial behavior is apparent when one considers the fairly well established thesis that the basic elements of personality are established during the first five or six years of life. Through the prenatal and maternal health services, the well child conferences, and the work of obstetricians, pediatricians, and general practitioners in private practice, health workers have more frequent contact with children during these crucial years than do any other professional group that serve the family. Health workers are in a strategically advantageous position to foster the development of good parent-child relations at a time when such relations are particularly important.

To derive the full benefit from their position, health personnel will want to strengthen and extend existing services and embody within their practice a concern for the total personality of their patients. In the past much of the emphasis has been on physical care alone. In more recent times we have begun to see that the psychological and physiological elements of life are so interwoven that we can not make a partial approach to the patient. The idea of the totality of the human organism is well accepted but we need to see what practical steps are necessary so that it will be manifest in practice.

The basic preventive job of the health services will be done by those workers that have contact with prospective parents and parents of very young children. Here the aim will be to help parents to understand their children, to understand themselves in relation to their children, and to anticipate possible problem areas and ways and means of dealing with them. Not only can health personnel prevent maladjustment through parent-aid programs, they can also help to create a community environment conducive to healthy family life. Related to this latter function would be the community organization and education portions of health programs, and the official duty of health agencies in most communities to enforce minimum standards in housing and sanitation. Health personnel further contribute to the maintenance of mental health insofar as they are able to establish constructive relationships with all the children and adults to whom they render service.

In addition to the general preventive program, health workers are often in a position to take specific action concerning "high risk" conditions. In the matter of children born out of wedlock for example, health personnel and social work agencies can cooperate to see that unmarried mothers are given the services and care they need, and that they are helped to make careful plans for their babies--so that the infant will not suffer deprivation of maternal care.

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When basic preventive measures fail or have not been applied, health personnel have a responsibility to be alert to the earliest signs of maladjustment, particularly in children. Once maladjustment is detected there is the obvious further responsibility of taking appropriate action. In some instances the health worker himself might be the helping person; or he might obtain assistance from other health personnel; or he might refer those needing service to a source of help outside of the health services.

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The topics covered in conference group discussion and consequently discussed in this report include the way in which various types of preventive programs may be strengthened so as to advance opportunities for the healthy development of young people. In this respect, attention is given to the kind of maternal and child health services which should be available for all prospective mothers and mothers of very young children. Special emphasis is placed on ways and means of preventing deprivation of maternal care for infants and the responsibility of health services for unmarried mothers.

Also seen as part of the broad preventive program is the continuing responsibility for health supervision of children throughout the growth process. Here, there is envisioned not merely attention to pathological conditions, but rather the kind of service which addresses itself to both physical and mental health and seeks to keep the human organism functioning at the highest potential level of capacity. Considerable stress is placed on the manner in which adequate health supervision of young people can be fostered through family centered programs and methods of working with parents and potential parents so as to increase their ability to do a good child-rearing job.

Recognizing that, despite efforts at prevention, youngsters will still develop problems, the conference discussed the function of health workers in aiding children with problems, and therefore a major section of this report is devoted to this topic. This includes an account of the discussion bearing on the case-finding process and on the method by which the health worker without highly specialized training in the psychological sciences can still be an effective helping person. Particular stress is placed on the need to strengthen and improve services for children with physical handicaps; services addressed not only to the handicap itself but to the child with the handicap. The manner in which health services can work with official agencies on behalf of adjudicated delinquents is also outlined as is the process of making referrals to non-health agencies. Finally, there is discussed ways and means of coordinating services, training health personnel, and seeking new knowledge upon which sound program development may be based.

The material that follows, therefore, is a summary of conference discussion and reflects the opinion of conference participants, although it is probable that there are some statements included to which only a few of the conference participants would subscribe. It is the hope of the Children's Bureau that in the near future each topic considered at the conference

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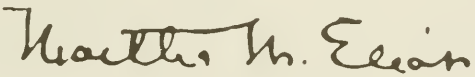

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Section I: BASIC PREVENTIVE ACTION

MATERNITY CARE

In the ordinary course of affairs, the health worker--a doctor, or nurse, for example--enters a child's life soon after the child has been conceived. Shortly after she becomes pregnant, if not before the mother usually seeks guidance from a physician or nurse or from a clinic or other health service. The health worker is thus given an opportunity to be an important influence--good, bad or indifferent--at the very outset of a child's life. In many cases, this influence can be exerted throughout the maternity cycle--that is, from the prenatal period, past delivery, and on into the postnatal care period.

Good maternal care is a careful blend of physical and psychological care, both based on understanding and knowledge of conditions in the woman's home. Expert physical care in itself has psychological value, of course, and there is no doubt but that the striking reduction over the years in maternal and infant mortality and in toxemia and other complications of pregnancy has enabled women to approach childbirth with a real sense of security. But health workers can offer psychological aid beyond this by responding with sensitivity to the personal needs a particular woman may have during her pregnancy. It should never be lost sight of that the patient is a person, with a personality and background all her own.

There are a number of specific ways in which health workers might offer an expectant mother additional psychological reassurance. One way is to be in contact with the woman more frequently during the early months of pregnancy. If the mother is receiving care from a clinic, the contact could be with the member of the staff with whom she has established the closest relationship. This need for frequent contact at the outset of pregnancy is particularly important for the young mother carrying her first child. Furthermore, as medical practice, this is sound and desirable, since complications that might appear later can perhaps be forseen and prevented or prepared for.

Continuity of personal relationship between the expectant mother and a health worker is another means of reassuring her. When the woman is in the care of a private physician, there is little question about this continuity In clinic practice it may be more difficult to arrange, but it is still not impractical. Wherever it can be arranged, this personal relationship should continue into postnatal care.

Still another contribution that can be made to the expectant mother's comfort and welfare is an appointment system. An appointment system shows consideration for the patient and enchances both her self-respect and her respect for the

clinic. Furthermore, an appointment system often makes
possible for husbands to accompany their wives to the clinic
giving clinic staff an opportunity to work with both parents

Occasionally, too, special circumstances require that healt
clinics make special arrangements for some of their patients
Thus when serving families of migratory workers, fo
example, patients might be served best by clinics that hav
evening hours.

Some women need additional care beyond the norma
This may be due simply to some aspect of their home situation
Or it may be that, in their case, because of certain physica
conditions pregnancy is a threatening experience to whic
psychological adjustment is difficult. Or the pregnancy ma
create an outlet for hidden emotional disturbance, or long
existing feelings of anxiety or insecurity may be heightened
In these cases the health worker may, by offering psychologi
cal aid, help minimize the possibility of a major emotiona
disturbance--both for the mother and the child. In certai
instances, psychiatric consultation or treatment must b
sought.

It is not always easy, however, to determine whether
woman's behavior during pregnancy is pathologic or "nor
mal." One conference participant stated that his work i
maternity care had convinced him that only experience ca
teach a health worker to make this distinction, that so far n
successful objective measures have been discovered. Th
team approach in clinic practice offers a great advantage i
diagnosis, in that the various members of a team--obste
trician, nurse, social worker, nutritionist, psychologis
perhaps--bring to the diagnostic process knowledge an
understanding of symptom and behavior that no one profes
sional person would usually have. But it was also remarke
that many hospitals and clinics do not use the team approac
as yet--or even have a full team. For example, according t
the latest figures available, only 3 out of 10 obstetrica
hospitals employ medical social workers.[1]

As for the kind of services needed to help pregnant mother
who manifest symptoms that might be considered pathologi
from a psychological viewpoint, one research center ha
estimated that four out of five such cases can be successfull
cared for and brought through pregnancy by their own phy
sician or by health services in their own community. I
other words, in most cases the task of helping the disturbe
expectant mother can be undertaken by the physician.

A major problem in maternity care is to reach the expect
ant mother early enough to be of help to her. Though at the

[1] Each conference participant received a document entitled "Some Facts About Healt
and Delinquency" as part of his preparation for the conference. The statistics quoted i
this report are, in the main, abstracted from that document. The sources from which th
statistics were drawn will be found in Appendix III. Exceptions occur in those instance
in which conference participants presented facts not included in the preparatory document.
When the source of information presented in the course of conference discussion is known,
it is given in a footnote.

resent time nearly all white babies and four out of five on-white babies are delivered by a physician, many pregant women either do not seek prenatal care at all or come o it very late. For example, it was reported that in one linic where prenatal care is a subject of particular study and esearch, it has been found that less than half the women elivered--either at home or in the hospital--had had contact vith a physician or a health service before their seventh nonth of pregnancy. Less than a third of these mothers later vent to a well-baby clinic.

Apparently one of the chief factors that deter or prevent nany women from getting adequate prenatal care is the high ost of medical services. By 1954 hospital costs had increased 55 percent since the end of World War II. By June 1955, bstetrical costs had increased 67 percent and physicians' ees 42 percent since the end of World War II.

Although many communities do not have adequate free or ow cost services, lack of knowledge of the services that exist s sometimes the reason why women who need care do not et it. Also, among some people there are cultural attitudes nd beliefs which mitigate against seeking prenatal care. Finally, the negative experience people may have had in the ast with health or welfare agencies makes them opposed or ittle inclined to make further contact.

Unfortunately, it is often the woman who needs help most vho does not seek it or who is prevented by some reason, eal or imaginary, from obtaining it. For instance, the case vas cited of a 24-year old woman admitted to a hospital for convulsions due to toxemia of pregnancy. She said she had ad no contact with a private physician because "doctors ost too much." Nor did she know anything about the care vailable to her through clinics. Another case cited was hat of a young woman admitted during the last week of er pregnancy and found to have an active case of syphilis. She stated that she had no idea that this could affect her child nd since she had had no other problem in her pregnancy and ad experienced no pain, she had not felt that she needed nedical attention.

The following were suggested as steps that might bring prenatal care to more expectant mothers: They are primarily ways of bringing the need for prenatal care to the attention of more people. Circulate literature describing the clinic's services and the expectant mother's need for service; this material should be made available to clinic patients for distribution to friends. Encourage high school teachers to learn about the services available and to disseminate information about these services; also encourage high schools to offer courses in family living and help them in the preparation of material for such courses.

Although maternal mortality has reched a record low in the United States as a whole, and in some communities is a rare occurrence, maternity care in general can still be greatly improved. There is definite need for a guide on ma-

ternity care in clinics, similar to the American Public Health Association guide, Health Supervision of Young Children. The American Academy of Obstetrics and Gynecology and the American Committee on Maternal Welfare are to be encouraged in their efforts to develop such a guide.

Many persons think maternity care should properly start with the pre-conception period. They advocate clinics to which prospective parents can come for diagnosis of their physical and mental state, for advice about nutrition and the processes and course of pregnancy. Cases are not infrequent of mothers going from one unfavorable pregnancy to another without medical advice and without the kind of preparation that might lead to a favorable outcome. In many cases by the time a doctor first sees the pregnant mother, three months of pregnancy have passed; in other words, the most vulnerable period for diet and metabolic change is over.

In future years, then, the concept of maternity care may have to be greatly expanded, as we learn more about how preparation for pregnancy and the pregnancy period itself can affect the life of the child to be born.

PREVENTING MATERNAL DEPRIVATION

In his monograph, Maternal Care and Mental Health, a report of a study made for the World Health Organization, John Bowlby says that ". . . what is believed to be essential for mental health is that the infant and young child should experience a warm, intimate continuous relationship with his mother (or permanent mother-substitute) in which both find satisfaction and enjoyment."[2]

The significance of Bowlby's conclusions insofar as the delinquency problem is concerned seems apparent. His monograph contains many quotations from studies relating to delinquent behavior stemming from maternal deprivation. Assuming that future studies will continue to bear out his hypotheses, the prevention of maternal deprivation could mean the prevention of a major part of delinquent behavior, both in terms of numbers of people involved and in terms of serious offenses against other persons.

For health workers this task of preventing maternal deprivation presents a real challenge. It is a task that they may not be able to accomplish alone but to which they can make a great contribution, in cooperation with the many other persons who work in behalf of children.

Health agencies can help to prevent maternal deprivation. They may provide sleeping quarters so that mothers may stay with their children when they are hospitalized. Otherwise, they should provide liberal visiting hours to allow the mother as free access to her child in

[2] Bowlby, John: Maternal Care and Mental Health. Geneva, World Health Organization, 1951. p. 11.

he hospital as is possible. A second way for health agencies o prevent maternal deprivation is to see that mothers have elp in caring for the home and children during the period vhen they are incapacitated. This help may be provided in a ariety of ways--such as by a relative; a maid employed by he family; or a homemaker employed, paid, trained and upervised by an agency serving the health and welfare eeds of the community. In this country homemaker service s still very limited and most of it is provided by social gencies. In England, however, local health authorities pro- ide a somewhat similar service known as home help service.

Of all children the child born out of wedlock is by the very circumstances of its birth most vulnerable to maternal deprivation. All that has been said above in regard to ma- ernity care has particular application here.

A considerable number of unmarried mothers are them- selves juveniles. Of the estimated 150,000 live births to un- married mothers in 1952, about two out of five were to women under the age of 20. An estimated 34,000 unmarried mothers--or more than one out of five--were aged 17 or less.

The youth of these mothers, in addition to their attitude toward their pregnancy, makes for definite health problems. Nutritionally they may be in a precarious state, since they are not far beyond the rapid growth spurt of adolescence. There is some evidence, too, to suggest that the possibility of toxemia of pregnancy is heightened with youth. Greater risk of toxemia means, in turn, greater risk of prematurity. How many of these young unmarried mothers--or unmarried mothers of any age--deliver prematurely is unknown. In any case, the combination of prematurity and illegitimacy is undoubtedly a formidable handicap for a child.

Little is known for certain about what happens to most babies born out of wedlock. Such information as we have comes from incidental studies. For example, studies for 1953 from two national social agencies that conduct maternity home care programs for unmarried mothers indicate that, in their case at least, five out of eight babies are immediately offered for adoption; about two out of eight are kept by their mothers; and the rest are temporarily placed in a nursery or boarding home, or some other such arrangement is made pending final decision as to what will be done with them. These agencies, however, account for only a small proportion of the total number of out-of-wedlock children born each year. Nothing definite is known about the babies of unmarried mothers who are delivered privately. Even where the initial disposition is known, further information is needed about what happens afterward. That is to say, of the mothers who keep their babies, how many keep them permanently or, if they later place them for adoption or in a boarding home, when do they take this step? In those cases where the baby is offered for adoption immediately, how soon is he actually placed?

In the case of most unmarried mothers it is evident tha they need both health and social services--services tha should be offered conjunctively. As has been indicated, they are an above-average risk group insofar as their health needs are concerned and certainly the same is true of their socia and personal adjustment.

To repeat, there is insufficient data on which to determine accurately what realy happens to most out-of-wedlock children. On the basis of such limited data as we have, however a rough picture of the distribution pattern can be sketched and a few of the danger spots in this picture indicated.

Many children born out of wedlock are adopted.[3] Of the children placed for adoption through social agencies, it is known that 3 out of 4 of them are children born out of wedlock. Birth out of wedlock and adoption thus are closely related problems.

In recent years there has been a decided move by adoption agencies to lessen the length of time in the placement process. Many babies are now being placed at much younger age than previously. More experience is needed before it can definitely be determined how soon a baby should be placed after birth--and under what conditions. However, a dangerous hiatus may exist for many babies between the time of birth and the time of placement. In 1953 more than one-half the children placed for adoption by social agencies were six months or more old. In raw numbers this was 13,000 children.

In review then it can be said that the child who is born out of wedlock is a "high risk" child in terms of future social adjustment. Much is being done of course to diminish this risk--both by maternity home agencies and associations, by adoption agencies, and by social service agencies. However, there are undoubtedly still many unmarried mothers and their children who get either none or only a fraction of the health and social service attention they need.

The strategic advantage health workers have in being of service to this group of children is only too obvious. Most out-of-wedlock births are attended by a health worker--generally a physician. In many cases the mother may already be known to a health worker, such as the public health nurse, during the prenatal period. Health workers, therefore, by the very nature of their profession, have the responsibility to see to it that every unmarried mother whom they attend receives not only medical service but also the social service she needs to plan properly for herself and her child.

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[3]Bowlby, in Maternal Care and Mental Health, reports that a study of the placement of over 1,000 babies by a London agency in the period 1949-1950 showed that only 17% were adopted. Bowlby reports that official government policy in England, as well as in The Netherlands and Sweden, is strongly in favor of the unmarried mother keeping her child. He indicates that this policy short-sightedly fails to take into account what actually happens to the child who is not adopted.

CONTINUOUS HEALTH SUPERVISION

One point that was repeatedly made--and lamented--by the members of the conference on Health Services and Juvenile Delinquency was the lack of continuity of health supervision for children and young people.

In communities where services are limited, it was pointed out, the child is seen by a health worker only rarely--at birth, for example, when he goes to be immunized, when he enters school for the first time, or in the case of an illness requiring emergency medical attention. Then there may be an occasional special examination, such as a dental examination. Under these circumstances the child all too often does not receive continuous health supervision.

Even in communities where services are comparatively numerous and well developed the conferees felt that the amount of health attention a child receives is apt to be far from what he really needs and varies considerably according to the economic status of his parents. In addition to the occasions mentioned above, he may as an infant be taken to a well child conference; perhaps he is seen again in a nursery school; he may be examined every school year rather than just the first year. Of course, these additional contacts have value beyond the mere number of contacts. A single visit to a well child conference, for instance, may have lasting effect if the mother in this contact learns simple rules of physical and mental health that she can apply herself in the care of her child. Likewise, school health workers, by acting as consultants to the teaching staff and to parents, multiply the effects of their services and achieve far more than they could accomplish themselves by direct contact with the children.

The discussion brought out that this lack of health supervision through the years has a number of truly harmful results. An obvious one is that handicapping conditions may exist or may occur and go without attention for long periods of time--often ending by doing much harm to the development of the child. Truly dismaying is the frequency with which children are found on routine examination to be still suffering from an ailment or handicap that was spotted in an earlier routine examination--but nothing had been done about it in the meantime, there has been no follow-up. Further, there is the fact of the number of specific disorders in childhood that continue to go untreated. Probably the greatest loss of all from lack of continuous health supervision is the loss of opportunity for the practice of preventive medicine--with all that this means in helping children develop to their full physical and mental potential.

The May conference discussed health supervision of the child according to the age of the different groups. For convenience this plan is followed here.

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The Infant And The Preschool Child

One of the two periods in a child's life when regular health supervision is likely to be conspicuously absent is during the preschool years; the other is early adolescence. These lacunae in continuous health supervision seem to be due in most part to lack of services, and to some degree, to lack of demand for service. It is true that once their child has safely gotten through the first years or so of life, some mothers do seem to show a lack of interest in further health supervision. This may possibly be due to the pressure of other responsibilites in the home or it may be due perhaps to a failure to appreciate the value of preventive health supervision (which in turn may be due to the failure of the health workers with whom the mother has had contact either to practice preventive medicine or to make her aware of its importance).

On the other hand, it is true that health workers--certainly public health agencies--often do neglect both the preschool child and the adolescent, and there is some evidence to indicate that were more services offered for these two groups (as well as for children of other ages), they would be fully utilized. The reason for the neglect is perhaps understandable--generally, a limited budget and limited personnel. Thus in some cities public health well baby clinics are closed to all except infants. In other places, the limit is children who are 2 years of age. However, there are other reasons for this neglect, reasons that are not always so acceptable. For instance, it was said that some health workers feel more comfortable with babies than they do with children of an older age, that they therefore openly or subtly discourage mothers with older children from coming to them except in the case of emergency illness. Further, some health workers use the well child conference simply to give inoculations and to look for disease. Consequently, the mothers, once the shots are completed, have little reason for returning. In some communities however, the well child conferences are open to preschoolers and it is reported that attendance at these conferences is good and remains good. There are instances too where well child conferences are set up exclusively for parents according to the similarity in age of their children. In other words there apparently is a demand for continued health supervision for young children and there might be a greater demand if mothers were to understand better the value of preventive health supervision and health workers were enabled to do a better job.

The American Public Health Association has recently issued a guide entitled Health Supervision of Young Children. The conferees felt that every physician and nurse who works with children would do well to study this guide. It covers the organization and process of the child health conference and also health supervision as it may be carried on by any doctor or nurse responsible for the health of children.

Since this APHA guide serves its purpose so well, there is no need here to go into details about health supervision for infants and preschool children. However, a number of comments were made on this subject at the conference that should be mentioned, most of them pertaining to the child health conference.

The child health conference without children was thought to have possibilities as a helpful supplement to individual interviews between the health worker and mother, with or without the child. Parents reassure and help one another when they share a common concern. As to who should conduct the conference--doctor, nurse, or some other person--the answer would seem to be whoever is the best group leader. Incidentally, some public health nurses are successfully conducting parent conferences made up of the patients of private physicians--without marring the physician-patient relationship.

In the case of individual interviews, it was thought that too many health workers use an assembly line technique, evidently feeling this is necessary in order to empty the waiting room. The remark was made that health workers can be more helpful to their patients if they understand them and to understand them it may be necessary to vary routine, to learn to listen more, and to be less compulsive about doing something.

Thus a doctor or nurse understand the mother-child relationship better if he or she sees the mother undressing the child rather than simply sees the child only after he is undressed. Similarly, giving a patient with special problems a single lengthy interview rather than several 15-minute spots is sometimes more effective in helping him and may be a timesaver. Sometimes, too, providing a playroom for the child to stay in and seeing the mother alone, is of more help to the mother than if the child were present. Having a playroom for the children, incidentally, was regarded by the conferees as one way in which the well child conference could be made more attractive for both the mother and the child. It was said that well child conferences should not be conducted as hurried, emergency-care affairs but should be occasions to which the mother and child can look forward.

One important statistical fact to note is that well child supervision continues to be and apparently will increasingly become a responsibility of private practitioners. Most well child supervision is presently in the hands of the general practitioner. The latest available data show that only 2 out of 5 countries have well child clinic centers supported by public or voluntary agencies. An important question that needs to be answered, therefore, is how effectively is health supervision being provided children in this age group?

The Early School Age Child

The two aspects of health service in schools that the conference felt most generally needed attention were the way in which the periodic examination of children is handled and the way in which health education is carried on.

The periodic examination given a school child obviously does little good if it is found that a condition noted for correction in one examination has still not been corrected at the time of the next examination. It is not surprising that school physicians who are confined in their work to simply making such examinations often suffer from a sense of futility and frustration. The reason why the child's condition has not been corrected can be one of several, it was pointed out. His family may not have a physician, being unable to afford one. The condition may be one that calls for services and facilities that do not exist in the community and for which the child would have to be taken to another community. Sometimes personal factors complicate the situation. The parents of the child may fail to take any action about their child's condition even though services are available to them. In some cases the child's family physician may disagree with the school physician's diagnosis.

One way in which the burden of the health problem for schools might be lightened, it was suggested, would be to discourage parents from depending so much on the periodic health examinations given under school auspices. In order to use their limited health services more effectively, some school systems are now encouraging parents to have their children examined periodically and treated by the family physician. With the major part of the student body thus taken care of, the school can then arrange for children whose families do not have a physician to be both examined and treated by the school physician, in his private office or through appropriate community agencies. Thus the school is able to do the maximum good with the limited services it is in a position to offer. In communities in which the school physician is limited to screening the children, it becomes his responsibility to work out a plan whereby those whose families do not have a physician can obtain the treatment they need.

Many school health examinations are at the present time limited to an appraisal of physical health focusing on the diagnosis of pathological conditions. The inter-relatedness of physical and mental health is a topic that needs to be emphasized throughout the school health program. It was recommended by the conference that school health examinations consider the physical and emotional status of the child and the degree to which he is functioning at the maximum level of his potential ability.

First-rate school health programs are characterized by the orderly fashion in which they approach their goal, namely helping children to develop to the full potential of their physical and mental health. Such services as health examinations and nutritional care are undoubtedly important parts of this program. In the better programs, however, these parts of the program are neither over-emphasized nor structured in tight little units unrelated to the child's home and school life. Conference participants were of the opinion that the school health program becomes more effective and more

pervasive in its influence if health personnel are used not only as medical specialists but also as advisors and consultants to other school staff. Health services and health education are interdependent. Consequently, the school health staff learns much about the health needs of children by observing them in settings other than the clinic--in the classroom, for example, or on the playground. Likewise, the health worker accomplishes more in the way of health education if he acts as advisor to elementary school homeroom teachers and in the secondary schools to the teachers of such subjects as science, physical education and home economics, all of which usually include material related to health and development.

A good school health program seeks through a total evaluation of each child to meet his needs and encourage his healthy development. A device that facilitates this evaluation is the cumulative record showing the physical and mental development of each child from earliest infancy on through his school years. Understanding of a child at any one moment would then be greatly heightened by knowledge of his past history.

A point particularly emphasized by conference participants is the fact that the school health program cannot be carried on alone by the health staff. It demands the cooperation of both school and other health personnel, of parents, teachers, and especially school social workers and various community agencies and private practitioners.

The Adolescent

As a rule, the adolescent is very concerned about his physical development and how it compares with that of his peers. He is also acutely aware of the impression his appearance makes on others, again particularly his peers. Being obviously overweight or underweight, for example, can be emotionally disturbing to a boy or girl of this age.

Health personnel and others through whom they furnish information are in a position to reassure both the adolescent and his parents about his development and growth. The changes that take place during this period, like those that occur in earlier phases, have been identified and can therefore be predicted. The job of the health worker often consists in correcting erroneous impressions adolescents have about their bodies as much as in giving accurate information.

One of the lacks in respect to better health services for adolescents is that, although there is considerable knowledge about "normal" development, this knowledge has not been formulated and passed on to a sufficient extent to those who can best use it. The May conference recommended that the Academy of General Practice, the American Public Health Association, the Academy of Pediatrics, and the Children's Bureau give greater attention to this phase of growth and development. Dissemination of information through the Academy of General Practice would be particularly constructive, since it is

the general practitioner who takes care of the large majority of children and young people. Nurses, too--particularly those working in schools--are often in an advantageous position to utilize such information.

Health workers are often asked by schools, for example, to give lectures to young people on the effects of alcohol, tobacco, narcotics, or drugs. Too often such a lecture is a hastily planned, one-time affair which either makes little impression or leaves the young people confused. There was general agreement at the conference that attention given in schools to the use of alcohol, tobacco, narcotics, and drugs should be part of a continuous, well-planned information and discussion program, whereby children can learn not only the properties each of these substances has and its effects when used in varying amounts but also how to judge for themselves in regard to their use. Many conference participants protested against health teaching that merely "lectures at" and does not actually involve youngsters in a learning process.

Community health services for adolescents are in many places conspicuously lacking. Diagnostic and treatment services are generally needed; convalescent facilities for adolescents are rare. Such health supervision as the adolescent gets is apt to be incidental--an occasional school health examination, for example. Obviously, if health services are to make their maximum contribution to the delinquency control effort, programs addressed to the care of the adolescent must be strengthened, expanded, and improved.

FAMILY CENTERED HEALTH SUPERVISION

One subject touched upon at the May conference was the feasibility of having clinics or centers to which the whole family could come for preventive health service. This system offers great advantages to the doctor, nurse, and other health personnel in that it allows them to become acquainted with the entire family and thus to form some estimate of the family environment and of the relations between various members of the family. The individual members of the family benefit in turn from this understanding of them that the health worker has. Likewise, the family centered clinic provides for the continuity of care so often stressed by conference participants. The most famous center of this kind was the Peckham Pioneer Health Centre, formerly located in London.[4]

Few of the elaborate physical attractions which existed at the Peckham Centre can be duplicated in a public or voluntary clinic or in a private, group-operated clinic, but some arrangements can be made to draw families to a center and to encourage their use of services to a greater extent than at present. Having playrooms and playgrounds, for example, means that the mother can bring her children with her when

[4] The Peckham Centre has been described in at least two books: The Peckham Experiment, by Innes H. Pearse and Lucy H. Crocker (London, George Allen and Unwin Ltd., 1943), and Health the Unknown, by John Comerford (London, Hamish Hamilton, 1947).

she comes to the clinic and at the same time frees her for private interviews with the doctor and other personnel without being distracted by her children. One large city hospital that is currently conducting an experimental family center type of clinic now plans to add a nursery school to its facilities. Also, with such facilities and with a meeting place, groups of parents can gather together to discuss with the clinic staff topics of mutual interest to each group.

Earlier in this report reference was made to the way in which an appointment system in clinics often makes it possible for husbands to accompany their wives and children. Another adjustment that may have to be made is to hold clinic at a time convenient for families as a group--in the late afternoon or evening, for example.

The primary aim of the family center clinic practice is to build health and thus prevent disease. The family centered clinic accomplishes this by furnishing continuous health supervision for all members of the family over long periods of time. This kind of practice means that the child who reaches school age or early adolescence is no longer dropped from service by the clinic simply because he has outgrown the pediatrician but is continued for service in the clinic without any noticeable change.

The family centered health clinic shows recognition of the influence on the individual of his immediate environment. Many people recommend that the clinic staff include social service personnel. Certainly the center that has a multi-disciplinary staff and that offers services to fit varied needs would seem to be an excellent medium of preventive medicine.

PARENT EDUCATION

One of the values achieved through the family centered type of health service operation is the opportunity of working with various members of the family so as to influence the development of constructive attitudes. Similar values may be obtained from properly staffed and organized parent education programs. While such programs can be conducted under a variety of auspices, health personnel have a particular interest in them insofar as the parent education program may be conducted as part of the well child conference or as part of the maternity care program.

While precise data is lacking, the impression is gained that many parents who participate in the parent education process first join a group when their child is of school age. While they may well maintain membership during the period in which they conceive and rear additional children, the value of involving both parents in the educational process at the time of the birth of their first child may well be lost. To gain full advantage of the parent education process, both parents should have the opportunity to participate in a child-rearing discussion group at the time of, or prior to, the birth of their first child. Health services have a unique opportunity

to work toward this goal by involving parents in educational programs when the mother first makes application for prenatal care. Many public health departments and some private practitioners are at present working with groups of pregnant mothers so as to provide information related to pregnancy, delivery, and care of the infant. In some instances these discussion groups involve both mothers and fathers, and in some instances they focus on the emotional as well as the physical ramifications of the life experience shared by members of the group. It is toward the multiplication of these few instances into many that the health services will want to move.

The values to be derived from the parent education process are twofold. On the one hand, parents are given an opportunity to gain information about child development and its variations so that their expectations will be in conformity with what is known about the growth of the human organism. Information may be provided regarding common problems in child rearing and various ways of handling those problems. The fact that such information is provided within the confines of a small discussion group makes it possible for the group leader to ascertain readily the degree of genuine understanding being achieved and sometimes to handle within the group blocks to learning that may be uncovered.

On the other hand, parent education programs offer a most important opportunity for engendering constructive parental attitudes toward children. For the purpose of working with "normal" parents the group has certain values other than those which can be obtained in individual consultations. Many parents, for example, gain strength and reassurance from each other. Ideas and attitudes which a parent might be reluctant to express in a person-to-person conversation may come out under the stimulation of the group. Parents with resistance to authority may be better able to accept an idea from another parent than from a professional consultant in an office interview.

To obtain these values it is necessary that the parent education group have skilled leadership. The group leader needs to have a command of the techniques of leading group discussion, of the concepts of group process, and knowledge pertaining to child rearing. Without such leadership parent education groups may become centers in which misinformation is traded.

In the group process there may be produced in certain parents with particular problems overwhelming anxiety that is more harmful to parent-child relations than helpful. For such parents there needs to be individualized therapeutic facilities to which they may be referred. Even if such therapeutic facilities exist, however, the absence of the skilled leader may make it impossible to determine which parent can benefit from the group process and which cannot.

Efforts to provide leadership training have gone forward under the auspices of institutes of child study associated

with universities. Recently experiments in the training of teachers, social workers and nurses for leadership in parent education groups have been made by the Child Study Association of America. Certain organizations conducting parent education programs have reported considerable success in training lay leaders for such groups.[5]

Poorly staffed and structured efforts at parent education have given rise to a recent wave of skepticism about the value of the entire parent education program. It has been claimed that such efforts may give parents an intellectual awareness of what they should do without the capacity to change their own personalities so that they can do it. Consequently, it has been held, parents come to feel guilty and anxious about their own role and instead of enjoying the parental experience see it as a test, and a test in which they have failed. Such unfortunate results may be the consequence of parent education efforts which essentially "talk at" parents without due regard to their ability to assimilate and make use of the information provided.

Critics of parent education programs frequently point to the failure of parents to understand the true nature of "permissiveness" in child rearing as evidence of the unhappy results of the effort to provide child rearing information to parents. It is said that parents come to believe that "modern" child rearing practice requires that they abdicate their parental responsibilities, exercise no controls, and set no standards.

In discussion of this point at the conference it was held that health personnel have a responsibility to dispel parental misconceptions regarding the nature of permissiveness and to aid parents to understand that permissiveness does not mean that a child should be allowed to do everything he pleases. By their very nature, children require that limits be set and much of the child rearing process is concerned with helping youngsters to accept limits and live within them. Limits must, of course, be related to the stage of development of the child and more responsibility needs to be given as the youngster develops. There needs to be consistency in the manner in which limits are set and the kind of limits that are set. Parents need to understand that the setting of limits is a mutual responsibility and that there must be agreement between husband and wife regarding their philosophy of child rearing.

In helping parents with this particular problem, health personnel should realize that they should not extablish these limits for the parents--that is, do the job for the parents--but rather help parents solve the problem of limits for and with their children. It is not the function of the health worker to take over the parental role. Limits, of course, vary with different social levels and cultural backgrounds. Health

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[5] Brashear, Ellen L., A Community Program of Mental Health Education Using Group Discussion Methods. American Journal of Orthopsychiatry 24:554-562, July 1954.

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personnel must beware of simply imposing their standards on parents; they require an understanding of the particular social, economic, and cultural background in which the family operates.

When parent education efforts are properly structured and staffed they can be helpful not only to parents of very young children but also to parents throughout the process of child growth and development. During each phase of development parents may be helped to understand the particular phase that a child is in, as well as their own attitudes. Acquiring such understanding is a valuable experience which may be carried over by parents into the next phase of the child's development. There is considerable anxiety among parents, for example, regarding the adolescent period and during the pre-adolescence of their children they often begin to anticipate problems. The fact that adolescence is a period during which a series of predictable changes take place is often overlooked. Parents may be helped in dealing with their adolescent child by a knowledge of the kind of changes that take place and an assurance regarding the normality of such changes. Discussion, of course, must also be focused on the attitude of parents toward these changes.

One of the chronic problems in fostering programs of parent education is that of encompassing large numbers of parents in the program. In order to reach the maximum number of parents who can be reached, a variety of approaches is necessary. In certain urban areas of economic deterioration, where parents are so beset by bread-and-butter problems that they cannot redily focus their attention on problems of child rearing, groups of parents may be brought together around some common problem other than, but related to, child rearing. A child welfare worker in Iowa, for example, reports that she has been conducting a discussion group composed of mothers who are recipients of aid to dependent children grants. The initial focus of this group was on the problems of living within the public assistance budget, but they eventually came to discuss the problems of child rearing. In rural areas the extension service of the U.S. Department of Agriculture has long combined family life, child development, and parent education activity with a general program directed at the particular problems of rural living.

To reach the unreached in parent education it is necessary that the content of the discussion and reading materials be geared to the educational level of the parents. While it is true that mothers with advanced schooling have shown a great increase in fertility in recent years, less well educated mothers continue to produce a large share of the children. In 1950, with a total of nearly 16 million children under 5 years of age in the country, the mothers of nearly 5 million had no more than grammar school education. The mothers of about 9 million had completed 1 to 4 years of high school and the mothers of 2 million had gone to college. While educational attainment may be only a rough measure of ability to com-

prehend and learn, it seems obvious that if the parent education effort is to be extended it must in part be geared to mothers who have enjoyed few educational advantages.

Still another persistent problem in extending the parent education process has been that of involving fathers. In discussing this problem, conference participants recognized that the role of the father in relation to his children seems to be changing, and that many fathers are sharing responsibility with their wives for the care of the children. One participant reported that in child care clinic in Baltimore about 20 percent of the children are brought to the clinic by the fathers alone. While, generally speaking, the assumption of mutual responsibility in child rearing was recognized as a healthy development, some concern was expressed lest the father assume too much of the maternal role rather than fulfilling his unique function in the family. In working with families, health personnel need to look at the whole family situation and understand it as a constellation with inter-play between all members. Parental and child needs must be considered.

Part of the difficulty that health workers have experienced in involving fathers in the parental guidance process may be related to their own attitudes. Several health workers at the conference admitted that they were not as comfortable in working with the father as they were in working with the mother. The fathers themselves may feel uncomfortable and they have not always been made to feel wanted. Experience suggests that when both parents are included in a group discussion, fathers appear to be defensive, although this is not true when the fathers meet alone. Obviously the problem of involving the father is one that warrants further exploration and solution in order to move ahead on the total parent education job.

Thus far the parent education program under health auspices has moved forward largely in public or voluntary child or maternal health centers. Some private practitioners of medicine refer patients to such groups and a few others maintain groups for their own patients. Ways and means need to be found whereby the benefits of the group process can be extended to recipients of both private and public care.

FAMILY LIFE EDUCATION

Parent education should not be confined to parents or expectant parents but may well begin with prospective parents who are still in school. As the age of mothers at childbirth tends to decrease, it becomes increasingly appropriate to offer preparation for family living during school years, since the gap between school experience and the experience of motherhood tends to be lessened.

Health personnel do not have a primary responsibility for family life education in the public school system. Since such education is part of the total curriculum, ultimate responsibility rests with the educational authorities. Health personnel,

however, can and should participate in the family life program and should take special responsibility for certain facets of it.

The conference participants recognized that the assignment of primary responsibility was of considerable import, since health personnel do not want to do anything to further compartmentalize the high school student. Conferees stressed the importance of having one member of the high school faculty carry responsibility as advisor to each pupil and to all other school personnel who participate in the pupil's educational program. This key individual should be responsible for interpreting pertinent information to the pupils' classroom instructors, physical education supervisor, administrative personnel, and others concerned with him. Such information should concern the youngster's needs and problems in relation to school program, his physical and emotional health, and his personal and family problems as they effect his ability to participate fully in the activities of the school. The person responsible for the individual student should aid others in planning modifications in the school program that may be indicated because of the student's particular problems, capacities, and potentialities.

Such individualization of the school program is basic to family life education for although it does not provide specific information, discussion, and guidance related to family life, it does provide the climate in which youngsters can grow toward maturity and eventually assume their proper role as family members. While specific family life education material may be offered at the high school level, education for family living actually starts in the kindergarten when teachers help children to share and to forego immediate pleasure for later reward. The entire curriculum needs to be examined to see wherein family life education material may best be placed. The American Social Hygiene Association has been aiding the school system in a number of States in performing this task and has prepared specific material[6] of value to teachers in developing family life education content.

Such material must, of course, be adapted to the need of different groups of youngsters. One needs to be aware, for example, of the cultural background of the children. Sometimes family life education in schools may conflict with what youngsters learn at home. Teachers need to be aware of the possible problems engendered by such a situation. Occasionally the family traditions, customs, and mores may be so far from the practices reflected in the curriculum that the beginning must be made in parent education rather than in family life education.

Health personnel will be particularly concerned with those aspects of family life education that have to do with the youngsters' reaction to physical development. In dealing with preadolescents, for example, health personnel have an oppor-

[6]Suggestions for Preparing Teachers in Education for Personal and Family Living by a Regional Project Committee, 1954. 101 pp. (mimeo.). American Social Hygiene Assn., 1790 Broadway, New York City.

tunity to help children with problems that concern the development of their own self and their own body image. Among this age group one finds many questions regarding sexual development, capacity, and conduct, and an opportunity must be provided for such questions to be posed and discussed.

Ideally, sex education is a parental responsibility and much emphasis needs to be placed on aiding parents in imparting sex information gracefully and in an appropriate fashion. Parents need to understand that a simple question requires a simple answer and that they need not feel pressed to go beyond the youngsters' need to have one question answered at a time. Sometimes it is found that parents are over-concerned regarding matters of sex and, unwittingly, seem to give sanction for sexual experimentation, or over-burden the child by providing more information than he is ready to assimilate. In providing sex education it is important to know what the child has already learned, to correct erroneous information, and to give ample opportunity to discuss additional questions.

The importance of sex education as part of the total preparation for family living through the school system cannot be over-emphasized. The United States Public Health Service reports that the incidence of primary and secondary syphilis shows a marked increase beginning at eleven to twelve years of age and reaches a peak at nineteen years. It is also found that the reported cases of gonorrhea begin to increase sharply at eleven to twelve years. We are forced to recognize that a definite venereal disease control problem exists in this age segment of the population. With another recent study of the Public Health Service indicating a definite positive correlation between one index of delinquency (the number of defendents in criminal procedings tried under the Juvenile Delinquency Act in United States district courts) and the incidence of venereal disease,[7] the idea is suggested that not only are some young people having sexual experience at an early age but that this is particularly true of those who are prone to be delinquent. Obviously therefore, health personnel must be concerned with the preparation which young people receive to deal with the sexual aspects of life.

When parents cannot do the job of sex education in the manner in which it should be done, then others must rise to the occasion. Physicians have an excellent opportunity when making physical check ups of children of pre-adolescent age to answer many of their questions and to give anticipatory guidance. Many girls, for example, have anxieties related to menstruation both before and after its onset. Such girls often have received considerable misinformation and appropriate health personnel should be prepared to discuss the topic with them. Sex information acquired from peers is not an adequate substitute for parental guidance, or failing that, for guidance from a well qualified person.

[7] Donohue, James F., et. al.: Venereal Disease Among Teen-Agers. Public Health Reports 70:453, May 1955.

Section II: HELPING CHILDREN WITH PROBLEMS

RECOGNIZING PROBLEM BEHAVIOR

Despite the best efforts of parents and community workers some children will develop problems that warrant correction. It is not sufficient therefore, that health services be concerned only with basic preventive activity; there must also be concern about those children and their parents who need special attention. A distinction may be made in health services between primary preventive service, which is aimed at keeping an individual from having an illness, and secondary preventive service, which is aimed at arresting the progress of a disease process in an individual. In all health work and particularly in mental health, it is necessary that the disease process be detected as early as possible and remedial action taken before the disease becomes so aggravated that remedy is difficult or impossible.

In order that secondary prevention may be accomplished it is necessary that health personnel recognize the signs of maladjustment in the young people with whom they deal. In some instances problem behavior can almost be anticipated because of the nature of the situation in which the child lives. For example, children being reared in broken homes or homes in which one parent is physically or emotionally incapacitated are more prone to develop problems than are more favored children. In instances in which an older brother or sister has run into difficulty and there is reason to believe that contributing factors still exist within the home, one might anticipate the development of problems among the younger children. Children who are victimized by racial discrimination or who dwell in deteriorated neighborhoods may be expected to manifest problem behavior in greater proportion than their more fortunate peers. Occasionally it will be found that families of high mobility move frequently because of parental difficulty in making adjustment which may in turn be manifested in disturbed behavior among the children.

Still another group of youngsters who seem prone to develop problem behavior, particularly dissocial behavior, are those who "drop out" of the public school system before completion of high school. In some instances, the very problems which made educational attainment difficult make adjustment to the workday world difficult. In other instances, the problem may have been created by a school curriculum inappropriate for the particular youngster which has engendered feelings of defeat and failure. While the basic correction of the broad problems which give rise to the "school drop out" rests with those primarily concerned with education, health personnel will want to give special attention to the drop-out and the potential drop-out.

Some health authorities believe that large numbers of delinquency-prone children are also accident-prone. Two conference members suggested that these aggressive, impulsive, danger-seeking youngsters expose themselves to risks which result in the breakage of bones as well as laws. The emergency room of the hospital may be, therefore, a good case-finding facility. In communities where there is an accident control center, the hospital reports each accident to the health department and the health department takes the responsibility of following it up by a telephone call or a home visit by the public health nurse. This is a tie between the health department and the hospital which should be strengthened.

To recognize deviant behavior, health personnel must have a knowledge of the limits of normality at the various stages of child development. Some find it easier to think in terms of behavior that is acceptable to family and community and behavior that is unacceptable. Such a formulation avoids the implication that there is one kind of behavior that can be deemed within the limits of normality no matter what the social, cultural, economic, or geographic background of the child may be.

Since all children exceed the limits of normality at some time or other, persistency is a valuable clue in detecting signs of maladjustment. Deviant behavior of a transient nature should be overlooked. Behavior inappropriate for the age of the child, however, which persists over a period of time and despite the best efforts of the parent at correction probably signifies a need for attention on the part of the health worker.

Behavior viewed as deviant by parents is not necessarily outside the limits of normality. The parents' concern, however, is of importance and requires action which may be as simple as reassurance or as complex as prolonged therapy for the parents in a psychiatric setting. An understanding, therefore, of the reasons for which mothers seek help with problems of child rearing is helpful not only in understanding the problems of the children but also the problems of the parent. At the conference, a psychiatrist connected with a particular child guidance clinic operated as part of a children's hospital listed the following reasons for which children are admitted to the child guidance service:

1. prolonged immaturity
2. somatic symptoms without knowm organic pathology
3. disruptive behavior such as over activity or temper tantrums
4. disturbances in habit routine
5. unusual fearfulness
6. behavior characterized by withdrawal and lack of social responsiveness

The same conference participant reported that most children coming to child guidance clinics are found to be preschool youngsters having problems relating to manifest or

passive forms of aggression. Since society does not accept manifest aggression in the form of assaultative or destructive behavior the children seen are more likely to be those who resort to passive forms of aggression such as bed wetting, negativeism, or vomiting. The problem with which the clinic deals arises not only from the aggression but also from the parents' reaction to it or the anxiety of the child or others about his aggression. The extent to which passive or manifest aggression in the preschool child is actually a precursor of juvenile delinquency is as yet unknown.

Health personnel operating in collaboration with the public school system have a particular responsibility for the early identification of children with problems. Children who have made poor adjustment up to the time of entering school are likely to make a poor adjustment in school. Other children, however, who have presumably made a good adjustment before entering school may begin to show deviant behavior in the school situation. Health personnel will want to work with class-room teachers so as to identify the children in need of service. Considerable progress has been made in teacher training programs in helping teachers to develop the skills needed to detect early symptoms of maladjustment. Such skills, however, cannot be fully utilized where classes are too large to allow enough time for attention to individual children.

There are, of course, problems manifest in school children that are very quickly recognized by all concerned. Numbered among these are stealing, truancy, and a failure to produce commensurate with capacity. Many juvenile delinquents have a history of truancy and large numbers suffer from reading disabilities. Even in school situations which preclude the detection of more subtle forms of personal maladjustment, health personnel in cooperation with the educators can and will want to give particular attention to those children who are chronically truant and those who manifest reading disability.

Even though health personnel who are connected with school systems may have special responsibility for case finding, no one health service can do the whole job. There are certain problems not manifest in the school situation that might well be detected by the general practitioner, pediatrician, public health nurse, or medical social worker. Health workers in all types of service are in a position to see problems that might otherwise be overlooked. The individual who is under medical treatment has let down a part of his defensive armour and, hence, it becomes easier and even natural for him to talk about personal matters. Such talk is of little significance, of course, unless the health worker is knowledgeable about the manner in which emotional difficulties are related to general personality development and how problems related to physical disorder influence the solving of fundamental problems in relationships with other people.

After recognizing such problems the health worker has three possible courses of action. He can, at least initially, deal with the problem himself, he can refer the child and his parents to a psychiatric service or to some specially trained individual within the family of health service, or he can refer the child and his parents to an appropriate welfare or community agency. The first step in any form of first aid is to recognize the situations that require expert attention. But in many cases the problems are shallow and do not require the attention of the mental health specialist, providing that the health worker is prepared to function as a first aid mental hygienist. The health worker so prepared will recognize that symptoms in themselves are non-specific and mean different things to different individuals. In viewing his patient he will see the symptoms within the framework of at least a general understanding of the construction of the human personality. With such a point of departure, he can by asking, listening, and looking, often find common sense answers as to proper corrective procedures.

The health worker cannot relieve himself of his responsibility to make an appropriate response to the emotional problems of life which the patient will invariably present to him. Moreover, referral to a psycho-therapeutic service of patients who do not require such specialized care is a disservice to both the patient and the psychiatric facility. Often the most effective help that can be rendered is that which is given when an individual is in a crisis situation and not two or four weeks later in the consulting room of the mental health specialist.

The parents whose children are in difficulty need help right away. The anxiety engendered at such times is acute. It is often the presence of anxiety that makes it possible for individuals in a crisis situation to use a small amount of help in a most constructive fashion. Recent experience in military psychiatry, for example, has demonstrated that first aid mental hygiene rendered to a soldier right behind the lines is more effective in restoring him to function than psychiatric assistance rendered long after the acute crisis has passed.

Practitioners of first-aid mental hygiene soon find that there are levels of working with parents and children that are therapeutic even though they are not characterized by the profound involvement of true psychotherapy. The basic element in most forms of psychological treatment is the relationship between the patient and the therapist. When health workers are ready and able to accept the needs of both parents and children and work with them on appropriate problems, the corrective emotional experience of the therapeutic relationship can be an integral part of our health services.

Often first-aid is the last and only aid that a person requires. Sometimes, however, first-aid is in reality a holding action awaiting specialized service. There are parents and children who will be recognized as requiring intensive

psychiatric treatment or case work help but for whom no service is available. In such instances it is important that the first-aid mental hygienist see himself as at least offering a supportive relationship until proper assistance can be found.

Sometimes the problem is not that the service is unavailable but that the family will not use it. The field of social work is presently very much concerned with developing ways and means to reach families who resist help as it is currently offered. Some cities have established special services for such families. Even if a family can't be reached it is sometimes possible for the health worker to find one individual in it that can be worked with and this is often worthwhile. Although participation of both parents is certainly much to be desired in working on a childhood problem it still is possible, if necessary, to work with a child without the active participation of the parents. Therapists who have embarked on such endeavors have been surprised at how much tolerance can be taught children who can learn to live with the people and the conditions surrounding them.

Many health workers resist the opportunity to be of service as first-aid mental hygienists because of the fear that they will injure parents and children should their emotional difficulties be too deeply rooted for treatment by such a topical application of knowledge. Such individuals are able to work better and with more self-confidence when mental health specialists are available, either as supervisors or as consultants. In any event, however, it seems likely that the danger of inflicting injury through the effort to aid with emotional difficulties is greatly over-rated. Actually, people in trouble receive guidance from all sorts of well-meaning neighbors, relatives, and casual acquaintances. The health worker properly prepared for the first-aid job has a better chance of being right than the well-intentioned but often ill-informed lay therapist that the troubled person encounters on every hand. In most communities, the only practical way of furthering the preventive mental health effort is for the general practitioner, the non-psychiatric specialist, the public health nurse, the medical social worker and other health personnel to assume their rightful role and deal with the whole patient and not just a part of him.

CHILDREN WITH PHYSICAL HANDICAPS

Health workers have a special interest in children whose emotional problems are connected with the presence of a physical handicap. In such instances, a primary goal is the correction of the handicap. Where this cannot be achieved or is only partially achieved, health personnel will want to work with the child and his parents so that they are able to live with the handicap. Even where total correction is achieved it is usually necessary to work with the parents and the child because of the psychological impact of the handicap prior to its correction.

There is little reason to believe that there is a direct relationship between physical handicaps and the production of delinquent behavior. The sole exception to this statement is found among youngsters who have suffered some brain injury or malformation. There is evidence that suggests that a small number of delinquent children are victims of brain injury or damage which is the cause of their aggressive behavior. An electroencephalograph study of fifty delinquent boys made by Jenkins and Parcella showed that thirty-three showed normal brain waves; six were border-line normal; eight moderately disturbed; and three severely disturbed. This study bears out the fact that there is no positive correlation between EEG abnormality and juvenile delinquency.

On the other hand, there seems to be some relationship between EEG abnormality and certain types of behavior disorders which might well lead youngsters into the juvenile court. The most frequent symptoms suggestive of the brain-injured child are: uncontrolled rage, episodic attacks which may be manifest in many different ways, periods of confusion, and marked changes in the personality of the child. Manifest during episodic attacks may be such delinquent acts as assault, arson, and indecent exposure. The total percentage of juvenile delinquency that is based on organic brain disorders is small, but some of the most difficult cases are so based. Unless recognized they cannot be treated. If undiagnosed, they can not be separated from the major group of delinquent children without brain damage and such cases will act like gravel in the therapeutic machinery. They will tend to break down procedures that are highly effective in re-educating children who have not suffered brain damage.

A careful and thorough diagnostic work-up is required in the instance of a child thought to be suffering from brain damage. Such a work-up will usually include the EEG examination. Often the EEG must be supplemented by psychological tests which may reveal deep brain damage not recorded by the EEG which records injuries on the surface of the brain only. After diagnosis, some improvement can be achieved through the use of drug therapy sometimes combined with psychotherapy. A program to prevent brain damage is difficult to achieve since little is known about the cause of these injuries. Undoubtedly, injury during birth process and blows on the head account for some, but it seems likely that more are caused by a variety of different viruses most of which have not yet been identified.

While brain damage may be directly responsible for inducing aggressive behavior and bringing a child into the toils of the law, other types of physical disabilities influence a youngster's concept of himself and may create emotional problems resulting in maladjustment, including delinquency.

There are in America a substantial number of youngsters requiring care because of a physical handicap. On the basis of limited data it is estimated that in 1952 there were about 275 thousand epileptic children under 21 years of age; and

about one million children from 5 to 17 years of age having orthopedic defects, other than foot defects, of sufficient severity to justify referral to a physician for treatment. Nearly five thousand infants are born each year with cleft-plate or cleft-lip or both. An estimated seven and a half million school children are in need of eye care. About two million children from 5 to 20 years of age have speech disorders of such severity as to interfere with their educational progress and social and emotional development.

Although many States have now made provision for recording congenital anomalies on birth certificates, this information sometimes is poorly recorded or not fully used. Health personnel might well assume more responsibility for securing as accurate and complete information as possible promptly. To make use of such information there is need for an expansion of crippled children services and better coordination among all health personnel. In such a program the general practitioner must be a key person, particularly in regard to the preschool child. Whereas other health personnel may not see the preschool child, the general practitioner is called into attendance when the child is ill. Since the attitude which the child develops toward his handicap begins to be set in the preschool period, it is necessary that the general practitioner be aware of the need for corrective therapy.

Since many of the physical disorders are either not correctable or not completely correctable, a great deal of the mental hygiene effort, must be directed at aiding children and adults to live with the handicap. The attitude of the health worker himself toward handicapping conditions is of considerable importance. Sometimes, anxiety is created in health personnel and they tend to impose upon a child unnecessary prohibitions which interfere with his ability to make a good social and personal adjustment despite his handicap.

Most parents of handicapped children quite naturally suffer feelings of disappointment, dejection, and often a sense that somehow they have been instrumental in handicapping the child. Out of such feelings sometimes comes an overt or unconscious rejection of the youngster whose main need is acceptance. For such parents the attitude of the health worker is particularly important since he sets an emotional climate which may be transferable. The health worker should be able to listen to the parents and give them a full opportunity to express their feelings about the child, even though the feelings may not be those generally considered as socially acceptable. Discussion groups for parents of handicapped children have been particularly successful since in such a group, with trained leadership, the parents gain strength from one another.

It is particularly important that school personnel have an adequate understanding of a child's handicap, its physical nature, and its meaning to the child. Health personnel should participate in the process of gearing the school activity program to the handicapped youngster's need. Unless medical guidance is fully utilized, children may be unnecessarily

excluded from activity or, on the other hand, may be forced to participate in situations in which they cannot compete with their peers. The good school physical education program will take into consideration the needs of all children, with particular attention being paid to the individual with a physical defect which does not permit him to participate in competitive sports.

A good crippled children's program will follow the child and not merely the child's handicap. A child being served by such a program should not receive segmented treatment by the specialist alone. He should receive treatment directed to specific pathology plus a high quality of general health supervision. It is not sufficient to have a pediatrician see a child at the time of admittance to the crippled children's program, with follow-up care given by the appropriate speciality. The pediatrician should continue to see the child and should coordinate the care of the child.

Children being served by specialty clinics in hospitals are often neglected from the point of view of general health supervision because of the difficulty in getting all medical specialists to sit down together and work out a unified plan for the care of the child. In some settings this obstacle is surmounted by having the pediatrician sit in on the special clinics and observe the child while the specialist is examining him. In this way both specialists work together, learn from each other, and so are able to help the child and his parents in a unified way. In all such settings there is need for one person to take responsibility for the care of the child and to coordinate the services he is receiving.

THE REFERRAL PROCESS

In some instances the psychological damage inflicted on the personality by physical handicaps or by other social or psychological factors is so great that the child and his parents need help of a special psychological or social nature. Assuming that agencies and individuals exist in the community to offer specialized therapeutic assistance, the health worker must determine which patients require referral. In some instances the need for referral to specialized mental health personnel is apparent because the manifest symptomatology is so severe that the task of helping is obviously beyond the capacity of most health personnel. At the other extreme are instances in which the problem is of such a superficial nature that the question of referral hardly needs to be considered. In the middle are a large group of cases in which trial and error will determine the action that the first-aid mental hygienist should take regarding referral.

When a problem persists or becomes more severe despite the best efforts of the first-aid mental hygienist then referral may well be considered. With experience in handling emotional problems of patients, diagnostic perception becomes keener. The well trained health worker finally

becomes quite proficient at distinguishing those problems he can and should work with, those which had better be placed in the hands of a mental health specialist, those which should be worked with for a time and then referred, and those which he can and should work with as a substitute for community services that are non-existent.

In some communities, even though long term psychological and social therapy are difficult to obtain, it is possible to secure diagnostic study of a patient. In such places health workers will want to avail themselves of this service, referring patients for study for aid in developing their own diagnostic understanding, for guidance in their own treatment of the patient, and for help in ascertaining whether they are dealing with a patient they can help or one who must have specialized mental health service. Some patients, such as the parent seeking placement for a child or the family seeking public assistance, must be referred in order to obtain some type of service not available through health services.

Once a decision to refer has been made the problem shifts from "whether to refer" to "where to refer." In large communities with many different agencies and organizations the process of selecting the right one may be quite complex. Some communities maintain, as part of their welfare planning apparatus, an information and referral service which can be quite helpful. Most communities issue directories of social agencies, but where there are many different agencies such directories may be confusing to persons not familiar with agency operation and procedure. Many community welfare councils have in the past arranged short informational courses for teachers in which there has been an opportunity to discuss the various agencies in the community and the kinds of service each offers. Similar opportunities to learn more about community resources might well be offered to health workers.

Health personnel fortunate enough to operate in a setting where they have access to a medical social worker usually do not experience difficulty in knowing where to refer or how to refer. The medical social worker is familiar with the various social, medical, and other agencies, talks their language, and can usually make an expeditious referral or help other people to make one. Where persons not trained in social work are making a referral, they must also give both the patient and the agency some kind of preparation similar to that which the medical social worker gives. For the patient this involves ascertaining whether or not he is really ready to accept the kind of help being offered by the agency. It involves a very realistic interpretation to him of just what he can expect from the agency. Equally realistic must be the information given to the agency about the patient who is being referred, including pertinent social and medical facts and information about the patient's attitude toward his own problem and toward the agency from which he is going to seek assistance.

For most health workers who are attempting to make a referral the major problem, in the instance of psychological or social therapy, is to find a professional resource with time available to serve the patient. However discouraging efforts to make such referrals may be, the effort should be made. Occasionally a health worker will assume that service is not available because of past experience when, in actuality, the situation has changed and service is available. Unless the effort to refer is made there is no way to measure the need for service. Moreover, occasionally a resource offering social or psychological therapy may have an interest in some particular kind of situation and be willing to accept certain patients for treatment even though they have rejected past referrals.

SERVICE FOR ADJUDICATED DELINQUENTS

Even though it is extremely difficult to locate resources which provide social and psychological therapy to prevent delinquency, once a child becomes officially delinquent the community is forced into action and some provision is made for his care--even though, in most instances, the provisions made are far from what would be desirable. The delinquent child, who has been placed in the legal custody of an agency, institution, or persons other than his natural parents, has need for and is entitled to health care and rehabilitation.

In 1954 approximately a million and a third boys and girls between the ages of 10 and 17 came to the attention of police officials in the United States because of delinquent behavior. A preliminary estimate of the number of children brought before the juvenile courts for delinquency in 1954 was 475,000. Many courts with juvenile jurisdiction make no provision for a health appraisal as part of the necessary case study. Physicians in private practice as well as public health offices might well confer with the juvenile judge in their own communities on the question of providing medical services for the juvenile court. In smaller communities it might well be possible to interest the medical society in providing health services for children coming before the court.

In some of the larger jurisdictions where medical services are available the quality and use of these services demands scrutiny. It has been reported that in certain jurisdictions a routine vaginal examination is made of all girls coming before the court, regardless of the nature of the conduct which brings them to the attention of the law. The erroneous assumption is made that such an examination supplies data on whether or not the girl has been sexually promiscuous. Sometimes such physical examinations are performed with little respect for the patient. Negative attitudes toward the utilization of health services may develop in adolescents as a consequence of unfortunate experiences in a court setting. There is every reason to believe that judges with juvenile jurisdiction would welcome the assistance of health personnel in securing and maintaining high quality health services for the court.

In 1954 about 155,000 youngsters brought before juvenile courts were held over-night or longer in a detention home, police station, jail, or other facility while awaiting action on their cases. Many other young people were detained in jails by police officials and later released without referral of their cases to court.

In a study of detention of children in Mississippi made in 1953 the Mississippi Children's Code Commission learned that at least one fourth of the children brought before the juvenile court in that state were being detained in jails. Information about such jails revealed that one-fifth were in poor repair, many were unsafe, and had been condemned for human occupancy, one-fourth had "dirty" cells and corridors, in nearly half the mattresses were unclean, in a third the toilet facilities were inadequate and unclean, and in more than half juveniles were kept in the same quarters with adult criminals.

A study of conditions in twenty-seven Illinois jails commonly used for the detention of children was made by the National Probation and Parole Association in 1951. The NPPA report of this survey included a description of a cell in one county jail in which children were ordinarily confined. "Children detained in that cell can only be seen by peeking through a six inch slot in the door. The dark and gloomy cell is in the basement of the building and in addition to cots, the only facility is an open toilet. In order for the children to see out of doors they must either stand on their cots or lift each other up to a small barred window." Both the Mississippi and Illinois studies found that it was usual in these county jails to keep children behind bars for the entire day without exercise or any kind of activity.

Reports show that detention homes especially designed for the care of delinquent children are in some cases no better than jails and sometimes even worse. Of one detention home in Illinois the National Probation and Parole Association said "the conditions under which the delinquent boys are held in basement cells are deplorable. This type of detention is little better than medieval and should be severely condemned." The Senate Sub-Committee to Investigate Juvenile Delinquency called the Washington, D. C. Receiving Home for Children a "national disgrace." Referring to the crowding of an average of 91 children into space for 43, the Committee stated "better provisions are made for the animals in our zoo."

A study of detention in California released in 1954 determined that "more than half of the juvenile halls in that State had no provision for any medical examination unless a child became ill or had some easily recognizable physical disability that required immediate attention." Yet in one large juvenile hall in California in which all children are given a complete physical examination upon admission, 46.8 percent were found to have one or more physical problems.

Obviously health personnel need to give immediate attention to health services for children detained in jails and detention centers in local communities. Plans need to be

developed for medical examination upon admission, for health supervision during their temporary stay, and for follow-up in the treatment of physical problems. Leadership may given by the public health authorities, the medical society, or some other health organization. In many communities the beginning must be made on questions of basic sanitation, although service must be eventually extended to encompass all that is needed for children.

A distinction must be made between centers for temporarily detaining children awaiting police or court action, and institutions for delinquent children to which youngsters are committed by the court for relatively long term care. Such institutions are usually operated on a Statewide basis, although some of the more populous counties operate their own training schools for long-term care and treatment. More than 40,000 boys and girls were committed to such training schools for delinquent children in 1954. The 1950 Census Bureau count of children in public and private training schools for delinquents revealed that more than 500 of the children were between 6 and 9 years of age and an additional 222 were less than 6 years old. Depleted resources for proper care of children in their local communities often result in the children's being committed to such State institutions where they are trained not only by the staff but also by the older delinquents.

Training schools for delinquents are frequently located in remote rural areas far from community medical care facilities. Superintendents of such institutions have a difficult time recruiting high quality health personnel to conduct their health program. With some noteable exceptions, health personnel at such institutions tend to be persons who have retired from more activity positions and lack the energy to give the necessary leadership. Often the training schools have excellent facilities for the hospital care of sick children, well equipped operating rooms, and the like, but no provision for admission examination and no program of health supervision while the child is in the institution.

Health personnel should take the opportunity to visit State institutions, review health services, and offer guidance to the institutional superintendent. Health personnel should work toward the development of institutional programs in which emphasis is placed upon a careful initial examination and continuous preventive health services while the child is in residence. Wherever possible the clinic and treatment services of State and local health departments should be made available to children in institutions. When public health resources are not available, the medical care facilities of the community should, when feasible, be used.

Every child should have access to a diagnostic center with a comprehensive, integrated physical and mental health service. Such a resource is required to meet the needs of children presenting problems beyond the scope of even the best institutional health program. When new training schools for

delinquent children are constructed, health personnel should participate in the planning and the institutions should be located within easy transportation distance from medical centers where diagnostic and treatment facilities are available. Such locations would make unnecessary the provision of elaborate operating facilities and hospital beds within the institution. Consideration should be given to the idea of having a competent State agency designated in each State to set and enforce minimum standards for health services to children receiving care in public and private institutions.

Section III: WORKING TOGETHER TOWARD COMMON GOALS

As knowledge in the social and biological sciences develops the inter-relationship of one body of knowledge to the other becomes increasingly apparent. Thus it is known that cultural attributes are important in understanding child behavior just as parent-child relations are important; that the psychic factors in the production of disease are intimately involved with the physical factors; that the biologically rooted response of the infant colors the psychologically rooted response of the mother to the infant--and essentially the complexity and inter-relationships of all professions involving human behavior is perceived.

Out of such perception has come an increasing similarity in the articulated goals of many professions. The public health worker is no longer interested merely in preventing or treating disease but in total health maintenance. The teacher is no longer interested merely in imparting knowledge but is interested in the "whole child." The social worker is concerned with the totality of experience as it bears upon his client. The psychoanalyst comes to realize that patients have families and live in communities.

As professional goals become broader and boundaries more difficult to perceive, pressure is placed on the individual practitioner to assimilate more and more knowledge so as to discharge his broader responsibility. Desirable as such one man inter-disciplinary efforts are, the pressure to incorporate so much knowledge seems to ignore the fact that the very expansion of each discipline which has made it possible to perceive interrelationships also makes it increasingly difficult for one person to gain command of any one discipline. Obviously, therefore, there needs to be some definition of the basic common core of information which must be mastered by all members of the helping professions. At the same time as such common core knowledge is imparted, the special contribution of each profession must be sharpened and the inter-disciplinary effort manifested by genuine team efforts in the community.

Essential for the team effort is a mutual understanding among the various professions. For example, health workers who have occasion to work with schools must understand the school as a social institution. The worker who gives consultation to a school must be aware of such small details as the close schedule on which schools run and the importance of being prompt for appointments. There should also be an awareness of the pressures under which a school operates, of the fact that everybody wants to tell the teachers what to do and how to do it. Some individuals go into schools with a chip on their shoulders because they have not examined their

own attitudes toward authority and at one time in their lives schools represented authority. Self knowledge and knowledge of the other person and the setting in which he works is necessary for good team work.

Capacity for joint effort cannot come suddenly when professional responsibilities which require it are assumed. Experience in joint effort is needed and should be provided as part of professional education. To give social workers, health personnel, and educators the common core of knowledge they require, the walls between graduate schools should be broken down so young people in training for these professions can learn to work together by learning together. The various forms of apprenticeship used in training for these different professions should include planned team experiences.

With the necessary basic knowledge and proper attitudes there are numerous specific ways in which the team effort can be furthered. In local communities representatives of health, education, and welfare organizations might come together in sessions, similar to a neonatal mortality committee, to consider instances of juvenile delinquency. Those agencies which have had contact with the delinquent child might bring records of their contacts. Together members of the various professions might uncover the reason for past failures and see ways and means in which they could prevent future instances of delinquency.

Physical surveys being made of school children might extend their personnel to include a psychiatrist and a social worker so that each might learn from the other. Members of professions with highly specialized knowledge might conduct educational programs for colleagues in their own profession or kindred professions. Thus a psychoanalytical society might offer a course to general practitioners on the interrelationship between physical and emotional disorders. Or the general practitioners might organize a course offering medical information for teachers or for social workers.

A very logical opportunity for team action occurs around chronic community conditions of import to all professions. The consequences of faulty city planning, for example, is equally deleterious to the children served by social worker, educator, or health worker. Joint social action on the part of the professions concerned can not only make a substantial contribution to community well-being, but can also bring the professions closer together.

Sometimes when an inter-disciplinary team functions in a formal fashion, such as in a clinic setting, problems arise regarding the question of the team leader. In health services the leader is usually the physician, who, as such, must try to develop an equal interest in all disciplines. At the same time he represents a specific discipline and has the responsibility for making his own unique contribution. This dual role is difficult to assume and new leaders sometimes find themselves neglecting their responsibility as team leaders and emphasizing their role as a team member with a special

contribution. In actual practice it is not necessary that one person invariably assume the leadership role. From time to time problems arise upon which various team members are best qualified to take leadership. In such instances leadership should be yielded to the best qualified.

Teamwork is, of course, impossible if members of one profession do not have members of a kindred profession with whom to work. Occasionally this can be surmounted by members of a particular profession employing a specialist in another profession on a cooperative basis. It is possible for example for private physicians practicing in an area without psychiatric service to band together and employ a psychiatric social worker, a clinical psychologist, or a psychiatrist. Where there is the ability and the will to work with others, ways and means for establishing effective interdisciplinary efforts will be found.

Section IV: TRAINING HEALTH PERSONNEL

The health worker must be aware of the various community agencies which provide special services for children or for emotionally disturbed individuals in order to use these services when they are appropriate. But if health workers are to fully discharge their responsibility for the prevention and treatment of juvenile delinquency, their own training must go far beyond mere didactic instruction in the dynamics of human development.

It isn't enough merely to provide information about a variety of crises that may accompany different stages of personality development. One conference participant pointed out that we have learned a great deal about what can go wrong with the feeding processes and this information has been widely disseminated. Possibly as a result, the participant held, well baby clinics are reporting few of the feeding problems which were once so prevalent. However, they report many more sleeping problems. Changing the form of parent-child relations from rigidity to relaxation does not necessarily lower the incidence of pathological character traits in children. Neurotic elements in the personality of parents which are of fundamental importance in parent-child relationships are not substantially influenced simply by changing outward form. The ordinary and normal childhood fears, such as separation and physical injury, will be difficult for a child to deal with if the events which generate such fears in the child also generate abnormal anxiety in the parent. Even if a parent has intellectually mastered and applies "modern" techniques for dealing with situations that engender normal fears in children, the child will not only respond to what actually transpires, but also, if it is present, to the basic anxiety of the parent about the situation.

It is obviously, therefore, not enough for health workers to be knowledgeable about common crises in child development and prepared to give advice to parents. They must also be able to sense, hear, and feel something about the parents to whom they are giving advice. The way in which they respond to parents' questions regarding child development must be custom-made to the particular parent. To accomplish this, the health worker must be prepared not only to listen to the parents, but also to evaluate the social, cultural, economic, constitutional, and psychological elements that bear upon the parents' capacity to function in a particular manner.

Even more important than the ability of the health worker to gather information and evaluate it, is his ability to understand his own self and to use himself in a constructive, helping relationship. The health worker is no different from any other human being, insofar as he brings to a helping

relationship his own feelings and his own personal needs. The health worker, for example, who is himself struggling with problems of dealing with authority, may find it difficult to aid parents in setting necessary limits. The health worker with a pronounced need to dominate may find it difficult to listen and may tend to instruct parents without regard to their capacity to use instruction. To aid health workers in dealing with such problems there should be incorporated in teaching procedures and in supervision ways and means of providing an awareness of self sufficient to enable the health practitioner to refrain from working out his own needs on the patient.

One of the outstanding characteristics of social work education has been the development of a particular concept of supervised field work for graduate students. This practice involves the placement of graduate social work students in social agencies where they handle a small, selected case load under the intensive supervision of a field work instructor. One of the major aims of the instructor is to aid the student in understanding and controlling the manner in which his own personal needs impinge upon the helping process. Experience has demonstrated that this type of training is invaluable in the production of good therapeutic personnel able to deal with personal and emotional problems and that, without this type of instruction there is a tendency to produce individuals who have an intellectual grasp of human development, but lack the skill to apply this knowledge.

A knowledge of self combined with a knowledge of human behavior and specific instruction and practice in utilizing interviewing techniques will do much to overcome the common resistance of health workers to the full discharge of their mental health responsibility. One conference participant reported that health personnel felt much more relaxed in their role as mental hygienists when they came to the realization that they did not have to "tell" the mother something, nor did they have to answer the mother's questions, or solve her problems. According to this conference participant, health workers were relieved rather than threatened when they understood that emphasis was placed on being a good listener, on aiding the patient to develop self-understanding, and on helping the patient to help himself rather than on having final and absolute answers to all problems presented.

Graduate and Undergraduate Education

The value of offering a basic core training in human development to allied professions has already been mentioned as a technique for increasing team-work between disciplines. This suggestion was made by conference members in reference to training health personnel and advocated as an efficient and effective method of graduate education. It was held that the basic curriculum in which graduate students of medicine, nursing, social work, and education might participate should

be concerned with growth and development, including physical, emotional, and social growth in different cultures and environments. Growth and development as taught in medical school often tends to emphasize physical growth at the expense of emotional and social growth. In recent years teacher education has emphasized development of course content concerning growth and development, although the psychodynamic base that makes this material most useful is sometimes lacking.

Basic training in growth and development should include some actual field work experience. At Cornell Medical School, for example, third-year students are assigned to a family with which they work both in the clinic and in the home. They are encouraged to observe and become knowledgeable about family interrelationships and their bearing on health maintenance. In addition to utilizing actual home situations as a training base, the school also makes available to the student opportunities for contact with a nursery school where they can observe and work with children in a group setting. At the University of California at Los Angeles, first-year medical students and nursing students visit homes so as to learn about family inter-relations and relations between the professions.

Conference participants agreed that the point in the learning process at which such field experiences were made available was of considerable importance. Some thought that such experiences might best be offered during the first year of training when the student is most perceptive. It was held that if the experiences are postponed until later years, the student is not as much interested in interpersonal relations as he is in physical pathology. Others thought that these experiences might better be offered in the later years of learning, since health workers receiving their graduate education would have mastered some content and would be able to bring something to the families with which they would work. They held that if the total program of education were properly organized, the tendency of students to focus on physical pathology would be minimized.

Responsibility for developing interest in the total person cannot rest entirely on a single growth and development course, no matter how good that course may be. It is necessary that consideration should be given to emotional and physical factors throughout the entire curriculum. Since, for example, parents usually bring their preschool children for medical service in relation to an emergency, some material regarding this age group might be introduced around that part of the curriculum that deals with the handling of medical emergencies. It might be possible to look not only at the injured limb, but also at the child's attitude toward the injury, the parents' attitude, and the significance of their attitude in determining the course of treatment. Skillful introduction of such material provides a spring-board for full discussion of various aspects of child development.

Training programs should not place major emphasis on psychological or social pathology, but must emphasize concepts of normality. One conference participant suggested that our knowledge of normality is so slight, that at the present time experience alone qualifies the health worker to distinguish between the normal and the abnormal. It was reported that at the School of Medicine of the University of Indiana studies were underway to develop objective measures to distinguish between normal and pathological reactions to pregnancy. While there is a tremendous literature on neurotic reactions to pregnancy, it is difficult to find a treatise on the well patient. The study underway in Indiana is using as subjects patients selected by obstetricians as typical of their practice. Members of various disciplines are studying these patients in an attempt to get as much information as possible about the normal, pregnant mother. Thus far, a tentative rough formulation has been developed which suggests that if a mother has accepted her pregnancy as a natural physiological change, if she is having support in her environment, if her husband is accepting this, if other relatives are accepting it, if her history is one of relative stability in the past, then we are dealing with normality and the mother needs little special care of a psychological nature over and above that rendered to any patient. Such studies as the one in Indiana will develop material on normality which can be incorporated in training programs for health workers.

In discussing the need to improve the basic educational processes so as to enable health workers to fulfill their responsibilities, it was noted that, while all professions are aware of the need for additional training, compensation is frequently incomensurate with the individual's investment in training. Attention must be given to upgrading salaries for such persons as medical social workers and public health nurses so that their compensation will bear some relation to the investment in adequate training. Special attention must also be given to the salaries paid health personnel in institutional settings and in public health departments. Inadequate compensation constitutes the major block to recruitment of personnel for institutional and public health work.

Improved compensation will stimulate the effort to provide all members of the health team with the necessary basic education. At present, the basic preparation given various team members varies considerably. The nurses working in the public health department, for example, are key persons on the public health team and yet their education and background is often less than that of other members of the team. At the present time, out of roughly 1,500 schools of nursing only 216 provide the baccalaureate degree. There are still a tremendous number of three-year undergraduate programs, though efforts are being made to raise standards. So far, according to conference participants, some members of the medical profession have resisted the efforts to improve

standards. It was agreed that all health workers should give support to the efforts of leaders in nursing education to improve the education of nurses.

Still another obstacle to improving the educational process for health workers is the difficulty of making room in existing curriculums for additional courses. This obstacle might be partially resolved by two measures. First, all professional curricula need to be reviewed to determine which courses now being offered are of less significance than they were some years ago and might be eliminated to make room for new material. For example, it might be found that more time is being spent on communicable diseases in the training of health workers than is justified in the light of the progress made in the prevention and treatment of such diseases, and that less time is spent on the problems of mental health than is justified in view of the incidence of mental diseases today. Secondly, it may well be found that much of the content dealing with social, cultural, and psychological development can be built into the curriculum around subjects currently treated, rather than offered in special courses that must be added to the curriculum.

The effort to incorporate into the educational program material relating to psychological aspects of care will encounter considerable resistance unless a role is defined for health workers that does not leave them feeling isolated from what is their basic function. The broad orientation toward patient care should not be interpreted as minimizing the physical aspects of health and disease. Rather, psychological sensitivity should be thought of as enhancing the health workers effectiveness in carrying forward conventional health functions. This orientation must also be imparted to administrative staff since health personnel will be frustrated in attempting to fulfill their total function if they do not receive administrative support.

In emphasizing interdisciplinary effort it is well not to lose sight of the fact that an individual must have identification with his own profession and that professional lines should not be broken down to the extent of losing the unique expertese of the individual practitioner within a given discipline. In the development of health services there is need not only for those who can work together, but also for the scientist who can work independently, but lacks, perhaps, the qualities of temperament necessary for the team endeavor. One physician at the conference suggested that health workers in professional training be given an opportunity to gain confidence in their own profession and also an opportunity to work in a team relationship. Those who have a flair for working in teams will stand out and this capacity can be developed.

In-Service Training

Since many health workers now in practice have not had opportunity to benefit from the type of education outlined above

and since it will be a long time before all health workers have a basic understanding of human development, attention must be given to providing training for those already on the job.

Providing courses for practitioners is, of course, one method of on-the-job training. The conference commended the American Academy of General Practice as being the only medical society which requires that each of its members add something to their education annually. One conference participant held that when courses are offered to practicing health workers at a university or a major health center, the same group of workers tends to take advantage of each opportunity. Greater numbers of health workers are reached when professors from the university, or outstanding practitioners from the medical center, go out into the State and offer courses at points which are available and accessible to the large numbers of health workers who would not come to the medical center or the university.

New techniques for post graduate education are now being perfected. Foremost among these is the closed circuit television program which can bring to local medical societies and similar professional organizations particular educational program. Several of these have been offered across the Nation in recent months.

Such methods are extremely useful, but probably not as effective as the personal contact of teacher and pupil around an individual patient or a particular family. Supervision of the less-well qualified by the highly qualified is, of course, a time-honored technique for providing such personal contact.

Consultation is another method whereby teacher and student may have contact related to a particular case situation. Consultation provides a means of inter-disciplinary consideration and teaching and is, of course, particularly appropriate for those health workers whose traditional position makes supervision impractical. At the conference there was considerable discussion concerning the use of the consultation services of the psychiatric team. It was stated that in many areas of the country it was unrealistic to expect psychiatric, diagnostic, or treatment services for patients. In general, it was agreed that in such areas psychiatric consultation services, when available, could be best used not for direct service to patients, but in post-clinic conferences and in staff education. This would provide support for individual health workers in carrying on their relationship with patients as constructively as possible, rather than direct psychiatric service for a mere handful of patients.

Where mental health facilities exist on a permanent basis, the psychiatrist, psychiatric social worker, and psychologist should give considerable time to community activities, including training. The competency of the staff to participate in teaching through consultation and other means should be considered at the time a staff member is employed. Some conference participants suggested that child guidance clinics and similar services should select cases on the basis of the

degree through which they might, by working with a particular child and his family, promulgate mental health concepts among adults who have substantial contact with young people.

An effective way of providing additional training opportunities for staff now employed is the plan being worked out in St. Louis County where the mental health staff of the public health department is offering consultation to the various school districts. The program is a flexible one and takes into consideration the needs and problems identified by school administrators as well as the services that can be developed to help such administrators. Teaching methods include: (1) case conferences with small groups of teachers, and (2) seminars planned on a more formal basis for larger groups of teachers with opportunities to discuss concepts of child rearing and ways of working with children. The plan involves both health and education personnel and a pooling of resources between them. Teachers receive in-service training credit for participation in the program.

Special Attention to Adolescent Needs

In order that they may make their maximum contribution to coping with the problem of delinquency, health workers should have training that will improve their skills in working with adolescent youngsters. Health services personnel have real competency in dealing with problems of physical health among adolescents. But they need additional training to help them understand and know how to work with the social and emotional facets of the growing-up process. The physician, the public health nurse, the medical social worker, and possibly the nutritionist, the sanitarian, and the venereal disease investigator were mentioned at the conference as key individuals in the health field who have responsibility for working with adolescents and who would be able to use additional preparation.

Young people in undergraduate and graduate education are often so close to their own adolescent development that much of the material presented to them in regard to adolescence is missed. This may account, in part, for the failure of many young professional persons to work well with adolescents. Material regarding adolescence therefore, should be provided as part of the in-service training program and not only by universities and colleges training health workers.

Health workers must be made aware of how their attitudes and feelings toward adolescents and its problems may affect their ability to work with young people and their parents. It is much easier for most health personnel to understand and accept behavior problems in a young child than in an adolescent who manifests dissocial behavior. It is particularly difficult for health personnel not to convey their disapproval when they are dealing with an aggressive adolescent whose parents appear unconcerned about the youngster's behavior and unwilling to seek help.

The public health nurse can be a key person in working with an adolescent. Often she has known the youngster and his family through the prenatal and infancy period. The nurse serving in a school is also in a particularly good position to help adolescent girls because they will go to her for advice and help. Of course, the nurse needs to know which problems she can handle herself and which ones should be referred. Basic training courses for nurses should be reviewed and adjusted so that as much attention will be given to adolescence as is now given to infancy. In addition, in-service training programs for nurses should give more attention to the growing-up process in the teen-age years.

Often training material regarding adolescence can best be offered on an interdisciplinary basis, since all persons working with young people need training to help them handle day-to-day problems. Many teachers have ability to work well with adolescents, but need reassurance regarding their competency and help in identifying the problems they can handle as distinguished from those which require specialized treatment. All individuals working with young people, particularly those manifesting dissocial behavior, need help in handling resistance to treatment. Many social workers and nurses complete professional training without having any actual experience in working with adolescents. This should be remedied. Professional personnel should be given such opportunities during their training, with particular emphasis upon developing skill in interviewing adolescents.

Section V: NEW FRONTIERS OF KNOWLEDGE

The full development of training opportunities for health workers depends upon a continuing research effort to feed conceptual material into the training program. Unlike certain of their colleagues, whose major concern has been with the psychological aspects of human behavior, health workers are accustomed to operate on a basis of precise scientific information and are often uncomfortable when asked to apply concepts the validity of which is questionable.

The effort to develop new knowledge through the application of research techniques in the health field encounters several major obstacles which must be understood so that they can be overcome. The first and most obvious is, of course, the cost of a research effort. In addition to the cost factor, however, many embryonic research projects fail to develop because there are not a sufficient number of persons trained in research methodology to aid in designing and carrying on the necessary inquiry. Where research is initiated, it is often stymied by the difficulty of securing the cooperation of patients, who are the natural subjects of research having to do with human behavior. Even where that cooperation can be secured, it is difficult to introduce standard procedures, which are a necessary concomitant of research, when the practitioner is dealing with different patients having different symptoms, each requiring individualized services. Where standard procedures are used and the cooperation of patients elicited, there is still that major difficulty in all research having human beings as subjects, namely the infinite number of variables which impinge upon human development. Despite the fact that standard procedures have been methodically applied within the framework of a reasonably well-designed research project, the researcher often has difficulty in establishing cause and effect relationship when he comes to interpret his final results. The securing of adequate control groups in research endeavors concerned with human behavior is inevitably a time-consuming and costly procedure. In view of these problems, conference participants warned that research efforts should not attempt to encompass too much territory. They are often most helpful when their objectives are simple and clear and the study carefully designed, even though it is well understood that the results will be less than world-shaking.

Additional knowledge is particularly needed to strengthen the effort of the health services in preventing delinquency. At present it is difficult to make health workers see a relation between services offered to very young children today and events which may occur some twelve or fifteen years from today, because of the lack of precise knowledge regarding cause and effect in human behavior. The development of

aggressive activity in the human organism and the capacity of the ego to deal with aggression would appear to be one of the nuclear problems in understanding juvenile delinquency. Research effort, therefore, needs to be addressed to studies of parental behavior, particularly during the early years of life, and the relation of that behavior to the production of aggression and delinquency. Attention also needs to be given to the preschool child and his contact with the outer world, seeking to uncover the impact of culture on the production of aggression and ways and means by which the individual deals with hostile feelings. The approach to such problems might well be by means of longitudinal studies in which large numbers of youngsters are followed from birth through adolescence. Most studies in this field are retroactive and suffer from this fact. The longitudinal study could involve various disciplines in the scrutiny of how parental and communal influences make the handling of hostile feelings a problem and what makes some youngsters handle the problem by acting out, while others tend to behavior which is primarily self-destructive but not delinquent.

Such longitudinal studies would be sharpened if supplemented by cultural studies and by cross-cultural inquiries conducted to provide greater insight into the impact of various types of child rearing methods on personality development.

The previously referred-to formulation of John Bowlby regarding the manner in which depriving infants of maternal care may be related to the production of psychopathy in later life demands elaboration by additional research effort. Much more needs to be known about the effect of degrees of maternal deprivation and infantile discomfort less than those treated in Bowlby's works. More data is needed to answer the question of why some deprived infants grow up and make a satisfactory adjustment while others, subjected to similar deprivation, do not. More information is needed about the impact of multiple surrogate mothers on infants whose own mothers cannot give them consistent care or who are deprived of their natural parents and reared in multiple boarding homes or foster homes.

An epidemiological approach to the study of delinquency would be compatible with the tradition of the health services. This approach, which has proved so fruitful in the understanding of certain diseases, might yield much data on how delinquency is produced through a constellation of family and community factors. Through epidemiological studies it might even be possible to begin to isolate certain types of delinquency into snydromes having their own specific modes of prevention and treatment.

Lastly, there is need for evaluative research to determine the effectiveness of prevention or treatment programs. Such evaluative research might also be directed toward an examination of teaching methods. If, for example, we wish to determine whether a particular method changes staff attitudes, it is necessary to measure attitudes both before and after

training. One approach to the measurement of program effectiveness is that of attempting to determine the consumer reaction to services rendered. In one such study of a well-child conference, for example, it was found that parents thought immunization was the most important service rendered. Upon consideration the staff agreed that immunization probably was the most important service being rendered. As a result of such inquiries, health personnel may make their services more effective.

Throughout the conference there was agreement that not only do workers in health services have a responsibility for improving their own professional work, but they have an additional responsibility to interpret to other members of the community the need for health, education, and welfare services. It is only as health workers do their interpretive job that civic support can be mustered to develop research facilities, training opportunities, and necessary preventive and treatment services. It is, therefore, in his dual role as professional person and citizen that the health worker can and will make the maximum contribution to the solution of pressing community problems.

APPENDIX I

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APPENDIX II

PROGRAM

Conference on Health Services and Juvenile Delinquency

May 19-21, 1955
Washington, D. C.

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MAY 19th

9:30 A.M. - 12:30 P.M. OPENING GENERAL SESSION
(Room 5051, north building
Department of Health, Education, and Welfare
330 Independence Avenue, between 3rd and 4th Streets, S.W.)

Chairman: Martha M. Eliot, M.D.
Chief, Children's Bureau

Welcome: Philip G. Green
Director, Division of Juvenile Delinquency Service
Children's Bureau

Panel

(Discussion to be related to certain of the premises set forth in the agenda)

Leader: Bertram M. Beck
Director, Special Juvenile Delinquency Project

Participants: Reginald S. Lourie, M.D.
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Children's Hospital, Washington, D. C.

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Edward Davens, M.D.
Director, Bureau of Preventive Medicine
Maryland State Department of Health

2:00 P.M. - 5:00 P.M. WORK GROUP MEETINGS (in rooms as follows):

Group A (prenatal to 1) Room 5051
Discussion leader: Julius B. Richmond, M.D.
Chairman, Department of Pediatrics
Syracuse Memorial Hospital

Group B (preschool) Discussion leader:	Room G-755 Henry H. Work, M.D. Associate Professor of Pediatrics and Psychiatry University of Louisville
Group C (early school years) Discussion leader:	Room 4029 Richard E. Wolf, M.D. Director, Pediatric Psychiatry Clinic Children's Hospital, Cincinnati, Ohio
Group D (adolescence) Discussion leader	Room G-759-A Edward D. Greenwood, M.D. Consultant to Agencies, Schools, and Institutions Menninger Foundation, Topeka, Kansas

MAY 20th

9:30 A.M. - 5:00 P.M. WORK GROUP MEETINGS

Each group will meet in the same room as on May 19th, with the following exception:

Group A (prenatal to 1) Room G-747-A

MAY 21st

9:30 A.M. - Noon WORK GROUP MEETINGS

Group A (prenatal to 1)	Room G-747-A
Group B (preschool)	Room G-755
Group C (early school)	Room G-743-A
Group D (adolescence)	Room G-751

Noon - 1:00 P.M. BUFFET LUNCH

Executive Dining Room, street floor of north building

1:00 P.M. - 3:00 P.M. CLOSING GENERAL SESSION (Room 5051)

Chairman: Martha M. Eliot, M.D.

Discussion Leader: Arthur J. Lesser, M.D.
Director, Division of Health Services
Children's Bureau

Work Group Reports

General Discussion

APPENDIX III

SOURCES OF FACTS INCLUDED IN THE DOCUMENT, "SOME FACTS ABOUT HEALTH SERVICES AND JUVENILE DELINQUENCY" AND EMBODIED IN THIS REPORT WITHOUT FOOTNOTES

1. Number of children needing preventive care: parents, age groups

   Monthly Vital Statistics Report, vol. 3, no. 12 (Feb. 15, 1955). National Office of Vital Statistics;
   "Births by Attendant, United States, 1951," Vital Statistics, Special Reports, vol. 38, no. 15 (Sept. 12, 1954), National Office of Vital Statistics;
   "Births by Age of Mother, Race, and Birth Order," Vital Statistics, Special Reports, vol. 40, no. 10 (March 4, 1955), National Office of Vital Statistics;
   Bureau of the Census estimates.

2. Preventive medical care for mothers and children: who gives the care; community, maternal and child health services

   American Academy of Pediatrics, Child Health Services and Pediatric Education, Commonwealth Fund, New York, 1949;
   Facts About Nursing, American Nurses' Association, New York, 1954;
   Report of Local Public Health Resources, 1952, by Greve, Campbell, and Connor, U.S. Public Health Service, Washington, D.C.;
   "Medical Social Workers," section 3 of Health Manpower Source Book, by Knott, Pennell, Smith, and Wadman, U.S. Public Health Service, Washington, D.C., 1953;
   Release on "Maternal and Child Health Service, 1952-1953," dated Dec. 10, 1954, U.S. Children's Bureau;
   Estimates made by Children's Bureau on basis of U.S. Public Health Service health manpower reports.

3. Unmarried mothers and their babies: number, what happens to the babies

   Release dated Feb. 10, 1955, from National Office of Vital Statistics;
   Clark E. Vincent, "The Unwed Mother and Sampling Bias," American Sociological Review, vol. 19, no. 5, 1954, pp. 562-567;
   "Florence Crittenton Homes Association Report of Services, 1953," inserted as exhibit, p. 143, of hearings in Chicago, Ill., of Senate Subcommittee to Investigate Juvenile Delinquency, Oct. 27 and 28, 1954;
   Report of special study made available to Children's Bureau by Women's Social Service Department of Western Regional Headquarters of the Salvation Army.

4. Children lacking a permanent home: waiting adoption, in institutions, in foster care

   I. Richard Perlman and Jack Wiener, "Adoption of Children, 1953: A Statistical Analysis," Iowa Law Review, vol. 40, 1955, pp. 336-349;
   1950 census data, "Institutional Population," Bureau of the Census;
   "Children Served by Public and Voluntary Casework Agencies, June 1952," Statistical Series Bulletin No. 27, Children's Bureau;
   Arthur J. Lesser and Eleanor P. Hunt, "The Nation's Handicapped Children," American Journal of Public Health, Feb., 1954;
   Report of Local Public Health Resources, 1952, by Greve, Campbell, and Connor, U.S. Public Health Service, Washington, D.C.

5. Children with physical handicaps: number, medical services received

   Children's Bureau

6. Venereal diseases

VD Fact Sheet, issue no. 11, Dec. 1954, U.S. Public Health Service;
Summary of "Reported Venereal Diseases by Age, 1953," for the continental U.S. issued by the U.S. Public Health Service, 11 p., multilith.

7. Parent and family life education

"Births by Age of Mother, Race, and Birth Order," Vital Statistics - Special Reports vol. 40, no. 10 (March 4, 1955), National Office Bureau of the Census;
Release from Office of Education;
Extension Activities and Accomplishments, 1953, Circular No. 494 (May 1954), U.S Department of Agriculture;
Social Work Yearbook, 1954, American Association of Social Workers, New York.

8. Extent of juvenile delinquency

Children's Bureau

9. Treatment of delinquent children: detention, training school

Children's Bureau estimates;
"Detention of Children Prior to Court Hearing," Mississippi Children's Code Commission, Jackson, Miss., 1954;
The Detention of Children in Illinois, National Probation and Parole Association, New York, 1952;
California Children in Detention and Shelter Care, California Committee on Temporary Child Care, Sacramento, 1954;
Bureau of the Census.

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